REMARKS

In the amendments set forth below, Applicant has added dependent Claims 174-290 (which were numbered 38-153 in Applicant's March 30, 2010 Amendment) to depend from allowable independent Claims 1, 7, 17, 22 and 23, and Applicant has amended Claims 7, 9, 10, 11, 19, 22, 23 and 24 to correct informalities.

Just a few days ago, Applicant received a communication from the Examiner (dated July 2, 2010, received on July 6, 2010) indicating that Applicant's amendment after allowance had been disapproved. The Examiner noted that the "new" dependent claims 38-153 that Applicant had submitted did not appear to be numbered properly, in that they should have started with 174 (instead of with 38). Accordingly, Applicant has revised below those same claims to begin with 174. Other than those numbering changes, those claims remain identical to those that Applicant submitted on March 30.

In that communication, the Examiner also indicated that the newly added claims would not be entered because they "change the scope of the invention." Applicant was surprised at that part of the rejection, because Applicant had carefully drafted the amended claims so that they would all (1) depend from already allowed claims; and (2) be within the scope and language of claims that had already been pending and prosecuted previously in the case.

After receiving the July 2 PTO Response, Applicant's undersigned attorney called the Examiner to discuss these points, and the Examiner agreed to take a further look at the file. On July 8, the Examiner called back to explain that the basis of rejection was different than had been indicated in the July 2 communication. Instead of continuing the assertion that the amended claims "change the scope of the invention," the Examiner verbally indicated that he now was rejecting the amended claims based on MPEP 714.16, including the following specific provision:

"I. NOT TO BE USED FOR CONTINUED PROSECUTION

"37 CFR 1.312 was never intended to provide a way for the continued prosecution of an application after it has been passed for issue. When the recommendation is against entry, a detailed statement of reasons is not necessary in support of such recommendation. The simple statement that the proposed claim is not obviously allow able and briefly the reason why is usually adequate. Where appropriate, any one of the following reasons is considered sufficient:

(A) an additional search is required;

(B) more than a cursory review of the record is necessary; or

(C) the amendment would involve materially added work on the part of the Office, e.g., checking excessive editorial changes in the specification or claims.

"Where claims added by amendment under 37 CFR 1.312 are all of the form of dependent claims, some of the usual reasons for nonentry are less likely to apply although questions of new matter, sufficiency of disclosure, or undue multiplicity of claims could arise."

Applicant respectfully submits that, even if the foregoing MPEP provisions WERE deemed to be applicable to the present case (which Applicant does not concede), the final paragraph in the above quoted section should be the controlling principle, and the amendments should be allowed. Specifically, all of the claims 38-153 (renumbered as 174-290 below) are dependent claims, and therefore the "usual" reasons for nonentry should not be applied.

In addition, Applicant respectfully submits the Amendment should be entered because there are no questions regarding new matter, sufficiency of disclosure, or undue multiplicity of claims (again, as mentioned at the end of the final MPEP paragraph quoted above).

Moreover, to deny the entry of this amendment would require Applicant to undertake the expense and effort of prosecuting a related application all the way to issuance, just to obtain allowance of those dependent claims. Given the long and extremely complex prosecution of this

application, spanning nearly 12 years and at least four different Examiners, Applicant respectfully submits that Applicant should not be put to that burden, and that to do so would be extremely unfair and contrary to minimum standards of due process.

Contemporaneously with paying the Issue Fee for the above-referenced application, Applicant filed its original Amendment Under Rule 312. The substance of the Amendments below is identical to that original Rule 312 Amendment. The only changes are formal, consisting of renumbering the claims as requested by the Examiner.

In addition, for the mutual convenience of the Examiner and Applicant, Applicant incorporates by reference all of the remarks and related materials in Applicant's March 30 Amendment After Allowance, and adds the following remarks (some of which are similar or identical to corresponding portions of Applicant's March 30 Amendment).

Applicant respectfully submits that the language in new dependent claims 174-290 mirrors previously pending dependent claims of the application. Accordingly, those "new" claims do not require any additional search or examination. Among other things in that regard, Applicant sets forth below a chart detailing some of the locations in Applicant's original-filed specification where support can be found for each new dependent claim. Applicant respectfully submits that this list is not intended to be an exhaustive list and that support in the original-filed specification can be found in at least the places cited below, among others.

New dependent claim no(s).	Dependent claim language	Support in Original-filed Specification
38, 54, 62, 63, 64, 65, 67, 68	said collected information is used to prepare medical record documentation	Figure 4(f) Figure 4a6 Figure 4(b)
39, 55, 69, 70	said medical record documentation can be modified according to personal preferences for documentation	Pg. 13, l. 1-3 Pg. 16, l. 19 to Pg. 17, l. 8 Pg. 28, l. 4 to Pg. 29, l. 2 Figure 3
40, 41, 71, 72, 73, 74	at least some of said collected information is provided by said patient and/or any person on behalf of said patient	Pg. 15, l. 1-7 Pg. 26, l. 18-21

New dependent claim no(s).	Dependent claim language	Support in Original-filed Specification
42, 61, 88	said collected information is stored using said database and/or data table	Pg. 11, l. 14-17; Pg. 31, l. 7-16; Original claim no. 165
43, 77, 78	at least some of said collected information is accessible to a user before said user reviews information regarding, sees, or examines said patient	Pg. 15, l. 1-9 Pg. 18, l. 3-6 Pg. 26, l. 19-21 Pg. 30, l. 16 to Pg. 37
44, 57, 90	an adding means, wherein said user can add free text to said collected information, said free text entered by said user by means comprising voice dictation, voice recognition software, handwriting recognition software and/or direct keyed entry	Pg. 12, l. 4-19; Original claim no. 167
45, 91, 93	said prompting is customizable to accommodate needs of specific medical practices, medical encounters, or users	Pg. 13, l. 1-3; Pg. 17, l. 4-8; Pg. 26, l. 1-6; Pg. 28, l. 4-9; Pg. 33, l. 8-10; Original claim nos. 168 and 170
46, 92	said prompting is modifiable to accommodate changes in payer mandates and/or clinical practice	Pg. 13, l. 1-3; Pg. 17, l. 4-8; Pg. 26, l. 1-6; Pg. 28, l. 4-9; Pg. 33, l. 8-10; Original claim no. 169
47, 59, 60, 80	said electronic derivation of an appropriate billing code is customizable to accommodate the needs of medical practices, medical encounters, users, and/or specific billing requirements	Pg. 26, l. 1-6
48, 49, 50, 51, 52, 53	said resultant code is based on said algorithm	Pg. 13, l. 17-21 Pg. 14, l. 1-10 Figures 2 and 4(b)
56	said data forms comprise at least one of free text input, check box, drop down list, radio button, button, and/or selection list	Pg. 2, l. 11-16 Pg. 36, l. 1-10 Figures 5(a) – (i)
66	said billing code is derived based on rules set forth in the Documentation Guidelines for Evaluation and Management Services of the Health Care Financing Administration (HCFA), now called Centers for Medicare & Medicaid Services (CMS)	Pg. 4, l. 6-9; Original claim no. 163
75, 76	said data regarding said patient encounter is stored using said data storage means	Pg. 11, l. 14-17; Pg. 31, l. 7-16 Pg. 31, l. 11-16
79	said inputting means is customizable according to the preferences of specific medical practices, users, and/or specific billing requirements	Pg. 13, l. 1-3; Pg. 17, l. 4-8; Pg. 26, l. 1-6; Pg. 28, l. 4-9; Pg. 33, l. 8-10
81, 82	a populating means, wherein said user can enter data into one said individual data element and automatically populate more than one said individual data element regarding said patient encounter	Pg. 35, l. 17 to Pg. 36, l. 4 Figure 5
83	said patient encounter data includes patient counseling information and patient care information	Pg. 9, l. 10-11 Pg. 10, l. 20-21; Original claim nos. 139, 154 & 172
84	means for facilitating use of said patient encounter data for clinical care, prescriptions, counseling materials, educational materials, correspondence, quality assurance, billing, research, historical tracking and/or analyzing	Pg. 10, l. 20 to Pg. 11, l. 2 Pg. 17, l. 2-8 Figure 4(a) Original claim nos. 154 & 161

New dependent claim no(s),	Dependent claim language	Support in Original-filed Specification
85	said step of accessing said data including preparing communications regarding results of said patient encounter and said calculating means, said communications including documentation regarding what was found or what occurred during said evaluation, documentation sufficient to support said billing code, and/or communications to other health care providers.	Pg 9, l. 7-11; Pg 16, l. 14 to Pg 17, l.8; Original claim no. 160
86	said step of accessing said data including using said information in connection with clinical research, quality control, patient care data base information, clinical notes, clinical counseling notes, and/or correspondence	Original claim nos. 154, 161, 173
87	said calculating step including using a timer to track total time of patient encounter and total counseling time during said patient encounter, and using an algorithm to compare said total time of said patient encounter and said total counseling time during said patient encounter, and determining whether said billing code should be based upon said comparison	Pg. 17, l. 9-12; Pg. 27, l. 21 to Pg. 28, l. 3; Original claim no. 162
89	modifying said data base or data table as needed	Pg. 31, l. 11-16; Original claim no. 166
94	said step of accessing said data being customizable according to needs of said medical encounter or of said user	Pg. 28, l. 4 to Pg. 29, l. 2 Figure 3
95, 96, 97, 98, 99	said examination comprises portions of the body within 7 body areas and/or 12 organ systems	Figure 1a
100, 101, 102, 103, 104	said collected information includes a history which includes at least one of the following elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms	Figure 1b
105, 106, 107, 108, 109	said history is considered brief when it includes information relevant to one to three of the following elements of the present illness: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.	Figure 1b
110, 111, 112, 113, 114	said history is considered extended when it includes information relevant to four or more of the following elements of the present illness: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.	Figure 1b
115, 116, 117, 118, 119	said history includes a review of systems, said review of systems comprising information regarding one or more of the following systems: Constitutional, Eyes, Ears\Nose\Mouth\Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurologic, Psychiatric, Endocrine, Hematologic\Lymphatic, and/or Allergic\Immunologic	Figure 1c, page 22
120, 121, 122, 123, 124	said history includes a review of systems, said review of systems is considered problem pertinent when said review is selected from the following systems: Constitutional, Eyes, Ears\Nose\Mouth\Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurologic, Psychiatric, Endocrine, Hematologic\Lymphatic, and/or Allergic\Immunologic; and wherein said system is the system related to the problem	Figure 1c

New dependent claim no(s),	Dependent claim language	Support in Original-filed Specification
125, 126, 127, 128, 129	said history includes a review of systems, said review of systems is considered extended when said review of systems includes information regarding 2-9 systems selected from the following: Constitutional, Eyes, Ears\Nose\Mouth\Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurologic, Psychiatric, Endocrine, Hematologic\Lymphatic, and/or Allergic\Immunologic, and wherein said 2-9 systems include the system directly related to the problem	Figure 1c
130, 131, 132, 133, 134	said history includes a review of systems, said review of systems is considered complete when said review of systems includes information regarding at least 10 systems selected from the following: Constitutional, Eyes, Ears\Nose\Mouth\Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurologic, Psychiatric, Endocrine, Hematologic\Lymphatic, and/or Allergic\Immunologic; and wherein said at least 10 systems include information regarding the system directly related to the problem	Figure 1c
135, 136, 137, 138, 139	said history includes information pertinent to past, family, and/or social history; and wherein said past, family and/or social history is considered complete when information pertinent to at least two of three areas of said past, family and/or social history are included and the patient is an established outpatient, established domiciliary patient, established home care patient, or emergency department patient	Figure 1d
140, 141, 142, 143, 144	said history includes information pertinent to past, family, and/or social history; and wherein said past, family and/or social history is considered complete when information pertinent to three of three areas of said past, family and/or social history are included and the patient is a new outpatient, new inpatient, new domiciliary patient, new home care patient, comprehensive nursing facility assessment patient, hospital observation patient, or consult patient	Figure 1d
145, 146, 147, 148	said assessment and/or said decision is based at least in part on a Table of Risk, said Table of Risk being made available by The Health Care Financing Administration (HCFA) a branch of the United States Department of Health and Human Services, and now called Centers for Medicare and Medicaid Services (CMS) in 1995 Documentation Guidelines For Evaluation & Management Services or 1997 Documentation Guidelines For Evaluation & Management Services	Figure 1j
149, 150, 151, 152, 153	said billing code is derived based on rules set forth in the 1997 Documentation Guidelines for Evaluation and Management Services of the Health Care Financing Administration (HCFA), now called Centers for Medicare & Medicaid Services (CMS)	Figures 1a-1k, 2, 4c

Accordingly, Applicant respectfully submits that all of the pending claims are now in condition for allowance.

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If the Examiner would like to discuss any remaining or new issues regarding this communication, the Examiner is invited to contact the undersigned representative of Applicant at (949) 718-6750.

Respectfully submitted,

Date: July 12, 2010

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